STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
IN-PATIENT HOSPITAL CARE
HOSPITAL APPEALS OF REIMBURSEMENT RATES

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§1. Right To Appeal An Initial Agency Decision.

A. Right to Appeal: A hospital shall have the right to appeal (i) its prospective payment rate for operating costs related to inpatient care or other allowable costs, (ii) a calculation error made by the Department, (iii) a misapplication of Virginia's standards and methods of hospital rate-setting and payment, or (iv) the Diagnosis Related Groups (DRG) assigned to claims.

B. Time For Appeal. A hospital seeking to appeal pursuant to these regulations shall submit a written request to the Department of Medical Assistance Services within 30 days of the date of the document notifying the hospital of its prospective rate or notifying the hospital of its payment for individual patients.

The Department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the Department, whichever is later. Such agency response shall be considered the initial agency determination.

C. Required Information: A request to appeal the prospective payment rate must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) current and prospective cost containment efforts, if appropriate.

D. Non-Appealable Issues: The following issues will not be subject to appeal: (i) the organization of participating hospitals into peer groups according to location and bed size and the use of bed size and the urban/rural distinction as a generally adequate proxy for case mix and wage variations between hospitals in determining reimbursement for inpatient care; (ii) the use of Medicaid and applicable Medicare Principles of Reimbursement to determine reimbursement of costs other than operating costs relating to the provision of inpatient care; (iii) the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982; (iv) the use of the inflation factor identified in the State Plan as the prospective escalator; and (v) durational limitations set forth in the State Plan (the "twenty-one day rule").

E. Any issue which may be appealed shall include costs which are for a single cost reporting period only.

F. The hospital shall bear the burden of proof throughout the administrative process.

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§2. Administrative Appeal Of Adverse Initial Agency Determination.

A. General. The administrative appeal of an adverse initial agency determination shall be made in accordance with the Virginia Administrative Process Act, §9-6.14:11 through §9-6.14:14 of the *Code of Virginia*, as set forth below.

B. The Informal Proceeding:

1. The hospital shall submit a written request to appeal an adverse initial agency determination in accordance with §9-6.14:11 of the *Code of Virginia* within 15 days of the date of the letter transmitting the initial agency determination.

2. The request for an informal conference in accordance with §9-6.14:11 of the *Code of Virginia* shall include the following information:

a. the adverse agency action appealed from;

b. a detailed description of the factual data, argument or information the hospital will rely on to challenge the adverse agency decision.

3. The agency shall afford the hospital an opportunity for an informal conference in accordance with §9-6.14:11 of the *Code of Virginia*.

4. The Director of the Appeals Division of the Department of Medical Assistance Services, or a designee, shall preside over the informal conference. As hearing officer, the Director, or the designee, may request such additional documentation or information from the hospital or agency staff as may be necessary in order to render an opinion.

5. After the informal conference, the Director of the Appeals Division, having considered the criteria for relief set forth in §§4 and 5, shall take any of the following actions:

a. notify the provider that its request for relief is denied setting forth the reasons for such denial; or

b. notify the provider that its appeal has merit and advise it of the agency action which will be taken; or

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agency action which will be taken; or

c. notify the provider that its request for relief will be granted in part and denied in part, setting forth the reasons for the denial in part and the agency action which will be taken to grant relief in part.

6. The informal conference decision shall be rendered within 90 days of the conclusion of the informal conference.

§3. The Formal Administrative Hearing: Procedures.

A. The hospital shall submit its written request for a formal administrative hearing under §9-6.14:12 of the *Code of Virginia* within 15 days of the date of the letter transmitting the adverse informal agency decision.

B. At least 21 days prior to the date scheduled for the formal hearing, the hospital shall provide the agency with:

1. Identification of the adverse agency action appealed from, and

2. A summary of the factual data, argument and proof the provider will rely on in connection with its case.

C. The agency shall afford the provider an opportunity for a formal administrative hearing within 45 days of the receipt of the request.

D. The Director of the Department of Medical Assistance Services, or his designee, shall preside over the hearing. Where a designee presides, he shall make recommended findings and a recommended decision to the Director. In such instance, the parties shall have an opportunity to file exceptions to the proposed findings and conclusions. In no case shall the designee presiding over the formal administrative hearing be the same individual who presided over the informal appeal.

E. The Director of the Department of Medical Assistance Services shall make the final administrative decision in each case.

F. The decision of the agency shall be rendered within 30 days of the conclusion of the administrative hearing.

§4 The Formal Administrative Hearing: Necessary Demonstration Of Proof.

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A. As provided in § 1(F), the hospital shall bear the burden of proof.

B. A hospital seeking additional reimbursement for operating costs relating to the provision of inpatient care shall demonstrate that its operating costs exceed the limitation on operating costs established for its peer group and set forth the reasons for such excess.

C. In determining whether to award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, the Director of the Department of Medical Assistance Services shall consider the following:

1. Whether the hospital has demonstrated that its operating costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include, but are not limited to, the addition of new and necessary services, changes in case mix, extraordinary circumstances beyond the control of the hospital, and improvements imposed by licensing or accrediting standards.

2. Whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.

a. In making such a determination, the Director or his designee may require that an appellant hospital provide quantitative data, which may be compared to similar data from other hospitals within that hospital's peer group or from other hospitals deemed by the Director to be comparable. In making such comparisons, the Director may develop operating or financial ratios which are indicators of performance quality in particular areas of hospital operation. A finding that the data or ratios or both of the appellant hospital fall within a range exhibited by the majority of comparable hospitals, may be construed by the Director to be evidence that the hospital has taken every reasonable action to contain costs in that particular area. Where applicable, the Director may require the hospital to submit to the agency the data it has developed for the Virginia Health Services Cost Review Commission. The Director may use other data, standards or operating screens acceptable to him. The appellant hospital shall be afforded an opportunity to rebut ratios, standards or comparisons utilized by the Director or his designee in accordance

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with this section.

b. Factors to be considered in determining effective cost containment may include the following:

- Average daily occupancy
- Average hourly wage
- FTE's per adjusted occupied bed
- Nursing salaries per adjusted patient day
- Average length of stay
- Average cost per surgical case
- Cost (salary/non-salary) per ancillary procedure
- Average cost (food/non-food) per meal served
- Average cost per pound of laundry
- Cost (salary/non-salary) per pharmacy prescription
- Housekeeping cost per square foot
- Maintenance cost per square foot
- Medical records cost per admission
- Current Ratio (current assets to current liabilities)
- Age of receivables
- Bad debt percentage
- Inventory turnover

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- Measures of case mix

c. In addition, the Director may consider the presence or absence of the following systems and procedures in determining effective cost containment in the hospital's operation.

- Flexible budgeting system
- Case mix management systems
- Cost accounting systems
- Materials management system
- Participation in group purchasing arrangements
- Productivity management systems
- Cash management programs and procedures
- Strategic planning and marketing
- Medical records systems
- Utilization/Peer review systems

d. Nothing in this provision shall be construed to require a hospital to demonstrate every factor set forth above or to preclude a hospital from demonstrating effective cost containment by using other factors.

The Director or his designee may require that an onsite operational review of the hospital be conducted by the Department or its designee.

3. Whether the hospital has demonstrated that the Medicaid prospective payment rate it receives to cover operating costs related to inpatient care is insufficient to provide care and service to conforms to applicable state and federal laws, regulations and quality and safety standards.

See 42 U.S.C. §1396a(a)(13)(A). This provision reflects the Commonwealth's concern that she reimburse only those excess operating costs which are incurred because they are needed to

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provide adequate care. The Commonwealth recognizes that hospitals may choose to provide more than "just adequate" care and, as a consequence, incur higher costs. In this regard, the Commonwealth notes that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services ... that package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered -- not 'adequate health care'." Alexander v. Choate, - U.S. - decided January 9, 1985, 53 L.W., 4072, 4075.

D. In no event shall the Director of the Department of Medical Assistance Services award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, unless the hospital demonstrates to the satisfaction of the Director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality.

The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the state. 46 Fed. Reg. 47970.

In making such demonstration, the hospital shall show that:

1. The current Medicaid prospective payment rate jeopardizes the long-term financial viability of the hospital. Financial jeopardy is presumed to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss.

It should be emphasized that application of this marginal loss or "incremental harm" concept is a device to assess the potential harm to a hospital continuing to treat Medicaid recipients, and not a mechanism for determining the additional payment due to a successful appellant. As discussed below, once a threat to access has been demonstrated, the Commonwealth may participate in the full average costs associated with the circumstances underlying the appeal.

For purposes of this section, marginal loss is the amount by which total variable costs for each patient day exceed the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60% of total inpatient operating costs and fixed costs at 40% of total inpatient operating costs; however, the Director may accept a different ratio of fixed and variable operating costs if a hospital is able to demonstrate that a different ratio is appropriate for its particular institution.

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Financial jeopardy may also exist if the hospital is incurring a marginal gain but can demonstrate that it has unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long-term financial viability and,

2. The population served by the hospital seeking additional financial relief has no reasonable access to other inpatient hospitals. Reasonable access exists if most individuals served by the hospital seeking financial relief can receive inpatient hospital care within a 30 minutes travel time at a total per diem rate which is less to Department of Medical Assistance Services than the costs which would be incurred by DMAS per patient day were the appellant hospital granted relief.

With regard to the thirty minute travel standard, this requirement is consistent with general health planning criteria regarding acceptable travel time for hospital care.

E. In determining whether to award additional reimbursement to a hospital for reimbursable costs which are other than operating costs related to the provision of inpatient care, the Director shall consider Medicaid and applicable Medicare rules of reimbursement.

§5. Available Relief.

A. Any relief granted under §§1-4 shall be for one cost reporting period only.

B. Relief for hospitals seeking additional reimbursement for operating costs incurred in the provision of inpatient care shall not exceed the difference between:

1. The cost per allowable Medicaid day arising specifically as a result of circumstances identified in accordance with §4 (excluding plant and education costs and return on equity capital) and

2. The prospective operating costs per diem, identified in the Medicaid Cost Report and calculated by DMAS.

The Commonwealth recognizes that in cases where circumstances warrant relief beyond the existing payment rate, she may share in the cost associated with those circumstances. This is consistent with the existing policy, whereby payment is made on an average per diem basis. The Commonwealth will not reimburse more than her share of fixed costs. Any relief to an appellant hospital will be computed using patient days adjusted for the level of occupancy during the period under appeal. In no case will any additional payments made under this rule

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reflect lengths of stay which exceed the twenty-one day limit currently in effect.

C. Relief for hospitals seeking additional reimbursement for (i) costs considered as "pass-throughs" under the prospective payment system or (ii) costs incurred in providing care to a disproportionate number of Medicaid recipients or (iii) costs incurred in providing extensive neonatal care shall not exceed the difference between the payment made and the actual allowable cost incurred.

D. Any relief awarded under §§1-4 shall be effective from the first day of the cost period at issue. Cost periods for which relief will be afforded under these regulations are those which begin on or after July 1, 1996. In no case shall this limitation apply to a hospital which noted an appeal of its prospective payment rate for a cost period prior to January 4, 1985. Appeals noted prior to January 1, 1985, and any appeals relating to cost periods beginning on or after January 1, 1985 and before July 1, 1996 shall be governed by the appeals regulations effective August 22, 1985.

E. All hospitals for which a cost period began on or after July 1, 1996, but prior to the effective date of these regulations, shall be afforded an opportunity to be heard in accordance with these regulations if the request for appeal set forth in §1B is filed within ninety days of the effective date of these regulations.

§6. Catastrophic Occurrence.

A. Nothing in §§1 through 5 shall be construed to prevent a hospital from seeking additional reimbursement for allowable costs incurred as a consequence of a natural or other catastrophe. Such reimbursement will be paid for the cost period in which such costs were incurred and for cost periods beginning on or after July 1, 1982.

B. In order to receive relief under this section, a hospital shall demonstrate that the catastrophe met the following criteria:

1. One time occurrence;

2. Less than twelve months duration;

3. Could not have been reasonably predicted;

4. Not of an insurable nature;

5. Not covered by federal or state disaster relief;

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6. Not a result of malpractice or negligence.

C. Any relief sought under this section must be calculable and auditable.

D. The agency shall pay any relief afforded under this section in a lump sum.